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National Black HIV/AIDS Awareness Day — February 7, 2003

The third annual National Black HIV/AIDS Awareness Day will be February 7. The event will highlight the problem of human immunodeficiency virus (HIV) in the black community and aim to expand black involvement in preventing HIV. Supported by CDC through the Minority AIDS Initiative, the effort is led by a coalition of nongovernment organizations committed to stopping the spread of HIV and acquired immunodeficiency syndrome (AIDS) in the black community.

Blacks comprise approximately 12% of the population but account for more than half of all new HIV diagnoses each year (*1*). The 2001 rate of reported AIDS cases among blacks is 59.6 per 100,000 population, approximately three times higher than the rate for Hispanics and nine times the rate for whites (*2*).

HIV prevention programs designed for and delivered to those at high risk for HIV infection remain key to curtailing the HIV epidemic among blacks. For those who are already infected, getting tested is an essential first step for obtaining the treatment they need and taking steps to protect their partners from infection.

Information about HIV/AIDS in the black community is available from CDC at http://www.cdcnpin.org and http://www.cdc.gov/nchstp/od/nchstp.html. Additional information on National Black HIV/AIDS Awareness Day is available at http://www.blackaidsday.org.

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HIV/STD Risks in Young Men Who Have Sex with Men Who Do Not Disclose Their Sexual Orientation — Six U.S. Cities, 1994–2000

To avoid social isolation, discrimination, or verbal or physical abuse, many men who have sex with men (MSM), especially young and minority MSM, do not disclose their sexual orientation (*1–3*). Young MSM who do not disclose their sexual orientation (nondisclosers) are thought to be at particularly high risk for human immunodeficiency virus (HIV) infection because of low self-esteem, depression, or lack of peer support and prevention services that are available to MSM who are more open about their sexuality (disclosers) (*1–3*). However, the risks for HIV infection and other sexually transmitted diseases (STDs) are unknown for nondisclosers. To better understand the prevention needs of young MSM, CDC analyzed data from the Young Men's Survey (YMS) to compare HIV/STD risk differences between nondisclosers and disclosers. This report summarizes the results of that analysis, which indicate that 8% of 637 nondisclosers were infected with HIV compared with 11% of 4,952 disclosers. Among blacks, the prevalence of HIV infection was 14% among 199 nondisclosers compared with 24% among 910 disclosers. Compared with disclosers, nondisclosers had similar high risks for other STDs, reported less sexual behavior with men and more sexual behavior with women, reported less use of HIV testing services, and, among those who were HIV infected, were less likely to be aware of their infection. To reduce HIV/

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STD transmission among young MSM and their female sex partners, comprehensive HIV/STD testing and prevention programs for young nondisclosers, especially for those who are black, should be developed or expanded.

YMS was a cross-sectional survey conducted during 1994–2000 of men aged 15–29 years who attended MSM-identified venues in six U.S. metropolitan areas (Baltimore, Maryland; Dallas, Texas; Los Angeles, California; Miami, Florida; New York, New York; and Seattle, Washington) (*4,5*). Participants were interviewed with a standard questionnaire, had blood drawn for testing, and were provided HIV/STD prevention counseling and referral for care. Specimens were tested for HIV and hepatitis B virus (HBV) with standard assays. HBV infection was defined as the presence of HBV surface antigen or antibodies to HBV core antigen.

Disclosure was assessed with the following measure: "Using this card, choose the number that best describes how 'out' you currently are about having sex with men. By 'out,' we mean you let others know that you are sexually attracted to men." Responses were measured on a 7-point scale (e.g., 1, "Not out to anyone;" 4, "Out to half the people I know;" 7, "Out to everyone"). Participants who answered 1 or 2 were defined as nondisclosers, and participants who answered 3–7 were defined as disclosers. Participants who answered 1 or 2 were grouped together because of similarities in their demographic characteristics, reported risk behaviors, and prevalence of HIV infection. Differences between nondisclosers and disclosers were evaluated by using the Cochran-Mantel-Haenszel chi-square test controlling for city, age group, and race/ethnicity (if applicable). Analyses were stratified by race/ethnicity for those groups that had ≥50 nondisclosers. Some analyses were restricted to men aged 15–22 years because YMS was conducted in two different phases, and some questions were not repeated in the second phase, which was conducted among men aged 23–29 years.

In the six cities, 5,589 MSM participated in YMS (range by city: 815–1,060). The participation rate among eligible men was 59% (range: 54%–66%). A total of 637 (11%) MSM were defined as nondisclosers (range: 7%–14%); of these, 349 (55%) were aged 15–22 years (median: 22 years; interquartile range: 19–25 years). Black (18%), mixed-race (14%), Hispanic (13%), and Asian/Pacific Islander (10%) MSM were more likely to be nondisclosers than were white MSM (8%) ($p<0.05$). Among racial/ethnic minorities, age was not associated with nondisclosure. However, among white MSM, the proportion of nondisclosers decreased with age: 12% among those aged 15–19 years, 8% among those aged 20–24 years, and 5% among those aged 25–29 years ($p<0.01$).

Nondisclosers were less likely than disclosers to identify themselves as homosexual and to attend homosexually

identified bars and dance clubs ($p<0.05$), although 64% of nondisclosers attended these venues at least monthly (Table 1). Among MSM aged 15–22 years, nondisclosers were more likely to report that being homosexual or bisexual or having homosexual or bisexual friends was not important, that they sometimes disliked themselves for being homosexual or bisexual, that they felt isolated from others, and that the majority of persons in their racial/ethnic group disapproved of homosexuals ($p<0.05$) (Table 1).

TABLE 1. Percentage of men aged 15–29 years who have sex with men reporting selected demographic and psychosocial characteristics, and testing positive for HIV and hepatitis B virus (HBV), by disclosure status and race/ethnicity — six cities*, United States, 1994–2000

Characteristic	Black		Hispanic		White		All racial/ethnic groups	
	Disclosers† (n = 910) %	Non-disclosers† (n = 199) %	Disclosers (n = 1,391) %	Non-disclosers (n = 204) %	Disclosers (n = 2,237) %	Non-disclosers (n = 182) %	Disclosers (n = 4,952) %	Non-disclosers (n = 637) %
Regular venue attendance§								
Homosexual bars and dance clubs	77	64¶	83	69¶	80	56¶	80	64¶
Venue where participant was recruited	69	64	70	58¶	68	57¶	69	61¶
Sexual identity								
Homosexual	66	28¶	77	43¶	84	36¶	78	35¶
Bisexual	24	58	18	46	13	46	17	50
Heterosexual	1	6	<1	8	1	10	1	8
Transgender	5	2	3	1	1	1	2	1
Unknown/refused	3	7	1	2	1	7	2	5
Source of health care								
Private physician or HMO	45	43	46	49	56	52	50	47
Other	36	39	30	24	20	25	27	30
None	18	18	24	27	24	23	23	23
STD/HIV infection**								
Previous STD (self report)	21	27	18	15	21	16	20	19
HBV	23	20	15	12	13	9	15	14
HIV	24	14¶	10	6¶	6	3	11	8¶
Previous HIV tests								
None	24	29	21	35¶	19	37¶	21	35¶
≥3 tests	36	24¶	42	24¶	50	28¶	45	24¶
Perceived low risk								
(Excludes known positives; n = 5,457)	*(n = 888)*	*(n = 199)*	*(n = 1,343)*	*(n = 203)*	*(n = 2,184)*	*(n = 182)*	*(n = 4,821)*	*(n = 636)*
Being HIV infected††	79	84	80	83	86	86	83	85
Becoming HIV infected§§	59	68¶	55	55	63	60	60	60
Psychosocial¶¶								
(Aged 15–22 years only; n = 2,723)	*(n = 480)*	*(n = 100)*	*(n = 778)*	*(n = 118)*	*(n = 906)*	*(n = 100)*	*(n = 2,374)*	*(n = 349)*
Homosexual /bisexual identity not important	15	38¶	13	34¶	15	46¶	15	38¶
Homosexual/bisexual friends not important	25	40¶	24	30	17	33¶	22	33¶
Feel isolated from others	16	27¶	18	31¶	16	32¶	17	31¶
Sometimes dislike being homosexual/ bisexual	16	37¶	19	39¶	15	28¶	17	36¶
Most people disapprove of homosexuals	47	68¶	61	72¶	32	57¶	47	66¶

* Baltimore, Maryland; Dallas, Texas; Los Angeles, California; Miami, Florida; New York, New York; and Seattle, Washington.

† Disclosers were defined by answering ≥3 and nondisclosers were defined by answering ≤2 to the following question: "Choose the number that best describes how 'out' you currently are about having sex with men. By 'out' we mean you let others know that you are sexually attracted to men." Measured on a 7-point scale (1, "Not out to anyone;" 4, "Out to half the people I know;" 7, "Out to everyone").

§ Monthly or more frequently.

¶ $p<0.05$; Cochran-Mantel-Haenszel chi-square test comparing nondisclosers with disclosers, controlling for city, research phase (age group), and race/ethnicity (if applicable).

** STD = sexually transmitted disease; HIV = human immunodeficiency virus.

†† For research phase 1 (aged 15–22 years), measured by responding "no chance of it," "very unlikely," or "unlikely" to the following question: "Which of the following describes how likely it is that you are infected with HIV today?" For research phase 2 (aged 23–29 years), measured by responding "(1) very unlikely" or "(2) unlikely" to the following question: "Using this card, choose a number that best describes how likely it is that you are HIV-positive today."

§§ For research phase 1 (aged 15–22 years), measured by agreeing or strongly agreeing with the following item: "There is little chance that I could become infected with HIV, or infect others, from what I do sexually." For research phase 2 (aged 23–29 years), measured by responding "(1) very unlikely" or "(2) unlikely" to the following question: "Using this card, choose a number that best describes how likely it is that you will become HIV positive in your lifetime."

¶¶ Measured by agreeing or disagreeing with the following items (in order): "Being gay/bisexual/transgender is very important to my sense of who I am," (disagreeing); "It is very important to me that some of my friends are gay/bisexual/transgender," (disagreeing); "I feel isolated from others," (agreeing); "Sometimes I dislike myself for being gay/bisexual/transgender," (agreeing); and "Most people of my ethnicity disapprove of gays," (agreeing).

The 637 nondisclosing MSM reported a median of five male (interquartile range: 2–13) and three female (interquartile range: 1–12) sex partners during their lifetime. During the preceding 6 months, 212 (33%) reported having unprotected anal intercourse (UAI) with men, and 169 (27%) reported having unprotected vaginal or anal intercourse (UI) with women. For all racial/ethnic groups, nondisclosers reported less sexual behavior with men and more sexual behavior with women ($p<0.05$) (Table 2). Similar high proportions of disclosers and nondisclosers reported perceiving themselves to be at low risk for HIV infection and using a regular source of health care; however, proportionally fewer ($p<0.05$) nondisclosers had ever or repeatedly (≥3 times) tested for HIV (Table 1). Nondisclosers reported a median of only one previous HIV test (interquartile range: 0–2); 60% had either never tested previously or had not tested in >1 year.

No differences were observed in the high prevalence of HBV infection and self-reported previous STDs between disclosers and nondisclosers; however, the prevalence of HIV infection was lower among nondisclosers than disclosers (adjusted odds ratio [AOR] = 0.5; confidence interval [CI] = 0.4–0.7) (Table 1). Among nondisclosers, the prevalence of HIV infection was higher among blacks than all other racial/ethnic groups combined (14% versus 5% [AOR = 2.9; CI = 1.5–5.6]). However, black nondisclosers were more likely to perceive themselves to be at low risk for ever acquiring HIV compared with all other nondisclosers (68% versus 56%; $p<0.01$). Similar proportions of HIV-infected nondisclosers (n = 51) and disclosers (n = 522) reported engaging in UAI with male partners during the preceding 6 months (51% versus 50%) and injecting drugs during their lifetime (8% versus 12%). HIV-infected nondisclosers were more likely than disclosers to report being unaware of their infection (98% versus 75%; $p<0.01$), and during the preceding 6 months, having one or more female sex partners (35% versus 10%; $p<0.01$) and engaging in UI with female sex partners (20% versus 5%; $p = 0.01$).

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TABLE 2. Percentage of men aged 15–29 years who have sex with men reporting selected behavioral characteristics, by disclosure status and race/ethnicity — six cities*, United States, 1994–2000

Characteristic	Black		Hispanic		White		All racial/ethnic groups	
	Disclosers† (n = 910) %	Non-disclosers† (n = 199) %	Disclosers (n = 1,391) %	Non-disclosers (n = 204) %	Disclosers (n = 2,237) %	Non-disclosers (n = 182) %	Disclosers (n = 4,952) %	Non-disclosers (n = 637) %
Injection drug use								
Ever	4	2	8	3	8	10	7	5
Ever shared needles or equipment	1	1	1	<1	2	5§	2	2
Sexual behavior with women¶								
≥3 lifetime partners	40	61§	33	55§	31	61§	33	58§
≥1 partner	15	44§	11	33§	10	45§	12	41§
Main partner**	10	31§	6	26§	7	35§	7	31§
Casual or exchange partner**	8	26§	6	18§	7	29§	7	24§
Unprotected vaginal/anal intercourse††	7	23§	5	21§	6	36§	6	27§
Sexual behavior with men¶								
≥5 lifetime partners	72	56§	77	54§	83	49§	79	53§
≥3 partners	41	37	47	35§	52	35§	49	36§
Main partner**	72	64§	73	59§	74	51§	74	57§
Casual partner**	51	48	59	50§	64	55§	60	52§
Exchange partner**	9	10	9	11	6	8	8	10
Unprotected anal intercourse††	41	32§	47	42	48	27§	46	33§
(Aged 15–22 years only; n = 2,723)	*(n = 480)*	*(n = 100)*	*(n = 778)*	*(n = 118)*	*(n = 906)*	*(n = 100)*	*(n = 2,374)*	*(n = 349)*
Sex with men at public settings§§	20	12	20	18	23	15	22	16§

* Baltimore, Maryland; Dallas, Texas; Los Angeles, California; Miami, Florida; New York, New York; and Seattle, Washington.

† Disclosers were defined by answering ≥3 and nondisclosers were defined by answering ≤2 to the following question: "Choose the number that best describes how 'out' you currently are about having sex with men. By 'out' we mean you let others know that you are sexually attracted to men." Measured on a 7-point scale (1, "Not out to anyone;" 4, "Out to half the people I know;" 7, "Out to everyone").

§ $p<0.05$; Cochran-Mantel-Haenszel chi-square test comparing nondisclosers with disclosers, controlling for city, research phase (age group), and race/ethnicity (if applicable).

¶ Unless otherwise noted, behaviors were reported during the 6 months preceding the survey interview.

** Main partner = steady or regular partner, or lover; casual partner = nonsteady partner or one-night stand; exchange partner = partner with whom sex was exchanged for money, drugs, shelter, food, or transportation.

†† Inconsistent use or nonuse of condoms during intercourse during the 6 months preceding the survey interview.

§§ Includes any of the following locations: sex clubs, bathhouses, bookstores or video arcades, bars or dance clubs, public bathrooms, and parks.

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Editorial Note: The findings in this report are consistent with previous research suggesting that among MSM, nondisclosure of sexual orientation is associated with being a member of a racial/ethnic minority group, identifying as bisexual or heterosexual, having greater perceived community and internalized homophobia, and being less integrated socially within homosexual communities (*1–3,6*). Although this study did not find that nondisclosing MSM were at higher risk for HIV infection than MSM who are more open about their sexuality (*1–3*), the data suggest that a substantial proportion of nondisclosers are infected with HIV and other STDs and are at high risk for transmitting these infections to their male and female sex partners.

The finding that more than one in three nondisclosers reported having recent female sex partners suggests that nondisclosing MSM might have an important role in HIV/STD transmission to women. This might be particularly true for black nondisclosing MSM, of whom approximately one in five was infected with HBV and one in seven was infected with HIV. To help prevent further HIV/STD transmission among young MSM and their female sex partners, greater efforts are needed to increase public awareness and to develop or expand HIV/STD testing and prevention programs to meet the needs of nondisclosers, particularly those who are black.

The findings in this report suggest that public-awareness and prevention programs should be developed for nondisclosing MSM to reduce internalized homophobia and other factors that influence nondisclosure, barriers to HIV/STD testing and prevention services, low-risk perception, and high-risk behavior, including the risk for transmission to male and female sex partners. Corresponding efforts also should be developed for women to increase knowledge of HIV/STD acquisition risks from partners who might be bisexual and of where to obtain confidential testing and prevention services for themselves and their partners.

Prevention managers should intensify outreach efforts to provide HIV/STD testing, risk reduction, and health-care referral services to nondisclosers who avoid homosexually identified prevention organizations. Because this report and others (*6*) suggest that many nondisclosers have regular male and female sex partners, prevention managers should consider combining outreach efforts with partner counseling and referral services (*7*) and community network development strategies (*8*) to increase the availability of HIV/STD prevention services to sex partners of nondisclosing MSM.

In accordance with recently revised guidelines, health-care providers should routinely assess the HIV/STD risks of their patients and encourage at-risk MSM to test annually for HIV, syphilis, gonorrhea, and chlamydia, and to accept or seek vaccination against hepatitis A and B (*9*). To facilitate risk disclosure from young MSM, health-care providers should create discrete and nonjudgmental environments and ensure that patients are aware of confidentiality safeguards and of the importance of disclosing accurate risk information (*3*).

The findings in this report are subject to at least three limitations. First, information about the types of persons to whom disclosure was provided or withheld was not collected routinely. Second, the percentage of young MSM defined as nondisclosers in this report should be considered a minimum estimate because young MSM who are reluctant to disclose their sexual orientation were probably less likely to participate or report sexual behavior with men. Finally, findings might not be applicable to nondisclosing MSM aged >29 years or to MSM aged 15–29 years who do not attend MSM-identified venues or reside in one of the six participating cities.

The finding that all but one HIV-infected nondiscloser were unaware of their infection is consistent with a recent report suggesting that the majority of young HIV-infected MSM do not know they are infected (*10*). For more young HIV-infected MSM to realize the benefits of early diagnosis and care, and to help prevent further HIV transmission among young MSM and their female partners, health-care providers and federal, state, and local HIV-prevention managers should expand and improve HIV testing and prevention practices to meet the needs of diverse MSM, including those who do not disclose their sexual orientation.

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Hypothermia-Related Deaths — Philadelphia, 2001, and United States, 1999

Hypothermia is defined as the unintentional lowering of the deep body (core) temperature below 95.0° F (35.0° C). Hypothermia can be mild (90.0° F–<95.0° F [32.2° C–<35.0° C]), moderate (82.5° F–<90.0° F [28.0° C–<32.2° C]), or severe (<82.5° F [<28.0° C]). Common risk factors for hypothermia include exposure to cold while under the influence of alcohol or drugs, altered mental status, and immersion in cold water (*1*). During 1979–1998, approximately 700 persons (range: 420–1,024) died annually in the United States from hypothermia; approximately half of these deaths were attributed to extremely cold weather (*2*). This report presents three cases of hypothermia-related deaths in Philadelphia during 2001 as examples of risk factors for hypothermia and summarizes information about hypothermia-related deaths in the United States during 1999. Hypothermia deaths are preventable; by avoiding hypothermia, persons also can prevent other adverse health effects of cold weather.

Case Reports

Case 1. In January 2001, a man aged 60 years was found dead by police; he was lying on a sofa inside an abandoned house that had no heat or electricity. Other inhabitants in the house reported that the man had been drinking alcohol before his death. During the 24 hours before the man was found, the minimum temperature was 21.0° F (-6.0° C). On autopsy, the man was found to have a blood alcohol concentration (BAC) of 0.23 g/dL; in Pennsylvania, drivers are considered intoxicated if their BAC is ≥0.10 g/dL.

Case 2. In January 2001, paramedics were called to assist a man aged 25 years who was found unresponsive on a sidewalk late at night. The low temperature during the previous 24 hours was 31.0° F (-0.6° C). The man was transported to a hospital, where he was resuscitated through advanced cardiac life support protocol. He remained in a vegetative state and died 9 days later. His BAC at the time of admission was 0.48 g/dL; the underlying cause of death was listed as acute alcohol intoxication, with hypothermia as a contributing factor.

Case 3. In February 2001, a woman aged 48 years was found collapsed along a roadside. During the previous day, approximately 2 inches of snow had fallen, and the minimum ambient temperature had been 29.0° F (-1.6° C). After transport to a hospital, her core body temperature was 91.5° F (33.0° C). The woman died despite extensive efforts at resuscitation, including intravenous infusion and peritoneal lavage with warmed fluids. Autopsy revealed bilateral pneumonia and positive blood toxicology for morphine and diphenhydramine. Sepsis was listed as the primary cause of death, with hypothermia as a contributing factor.

United States

Since 1999, CDC's National Center for Health Statistics (NCHS) has used information from death certificates categorized with *International Classification of Diseases, Tenth Revision* (ICD-10) codes to estimate national mortality trends. During 1999, exposure to excessive natural cold (ICD-10 code X31) was listed as the underlying cause of death (i.e., the circumstance of the accident that produced the fatal injury) for 598 persons in the United States (Figure), and hypothermia (ICD-10 code T68) was listed as a nature of injury (i.e., an injury that occurred to the decedent) in 1,139 deaths (*2*). Of the 598 hypothermia-related deaths, 380 (64%) occurred among males, and 359 (60%) of the 597 persons who died of hypothermia and whose age was known were aged ≥65 years. During 1999, Pennsylvania and New York had the greatest number of hypothermia-related deaths (36 each) (*2*), and Alaska had the highest crude death rate (1.9 per 100,000 population), approximately twice that of Montana, which had second-highest rate (0.9).

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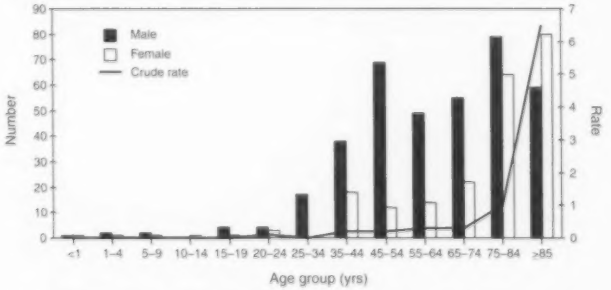
FIGURE. Number* and crude rate† of hypothermia-related deaths, by age group and sex — United States, 1999



* n = 597; excludes one hypothermia-related death of a man whose age was unknown.
† Per 100,000 population.

Editorial Note: Hypothermia is an important cause of preventable deaths in the United States, especially among persons who abuse alcohol (*3*). Ethanol causes vasodilation, which produces a brief "warming" sensation that interferes with peripheral vasoconstriction, the physiological defense against cold, while also inducing hypoglycemia. Alcohol consumption in cold surroundings is a dangerous practice. Unattended children and persons aged >65 years also are at greater risk for hypothermia (*3*).

Hypothermia during cold weather is the result of decreased heat production, increased heat loss, or impaired thermoregulation (*1*). Older persons, who have a decreased basal metabolic rate, might be at further risk for hypothermia because of impaired physical exertion, which produces heat to keep the body warm (*4*). Inactivity limits heat production through physical exertion, but overexertion can increase evaporation from the respiratory tract and cause fatigue. Shivering also can cause enough lactate generation eventually to produce acidosis and fatigue. Exposure to high winds can further increase heat loss. As body temperature decreases, the hypothalamus fails to compensate body temperature, and the central nervous system follows the progressive systemic depression of metabolism. Finally, metabolic impairment from alcoholism, malnutrition, hypothyroidism, or advanced age can cause poor endurance to cold (*4*).

Warning symptoms for hypothermia in adults include shivering, confusion, memory loss, drowsiness, exhaustion, fumbling hands, and slurred speech. In children, symptoms include bright red, cold skin and extreme low energy (*5*). Immersion in warm water is highly efficient in raising body temperature but might hinder cardiopulmonary resuscitation (CPR) and more invasive techniques if needed. Drinking warm, nonalcoholic beverages can help raise body temperature if the person is conscious (*5*). However, none of these procedures substitutes adequately for proper medical attention, and special care should be taken when handling and transporting a patient because skin can become numb and slough easily.

In the presence of severe hypothermia with cardiac arrest, CPR should be initiated on site and continued during transportation (*5*). Because of the protective effect that a low temperature might have on brain ischemia (especially if asphyxia has not preceded circulatory arrest), attempts at rewarming victims with severe hypothermia and cardiac arrest outside the hospital are not recommended (*6*). Core body temperature before rewarming might not be a good predictive factor for positive outcome, and persons with a core temperature as low as 59.0° F (15.0° C) have survived (*1*). The time between rescue and rewarming does not predict outcome (*1*); in the most extreme case, a boy aged 5 years recovered without apparent cerebral sequelae after 40 minutes of submersion in ice-cold water (*7*).

Overall death rates from all causes increase during winter (*3*); in addition to hypothermia, cold temperature is associated with excess mortality from ischemic heart disease (*8*) and cerebrovascular disease (*9*). Cold-induced vasoconstriction and later hemoconcentration can result in rupture of atheromatous plaques and arterial thrombosis. Cold temperature also can lower the immune system's resistance to respiratory infection, causing an increase in respiratory disease mortality (*9*).

Hypothermia-related morbidity is not exclusive to cold northern climates. Persons from regions with warmer winters might be at greater risk from the indirect effects of cold weather than persons from regions with colder and longer winters (*9,10*). However, geographic distributions might represent not only seasonal temperature variations but also socioeconomic status (which can limit access to controlled indoor temperature), cultural backgrounds (which can influence behavior toward individual protection from cold as well as outdoor activity), or populations with a higher proportion of elderly persons (*10*).

Persons should take precautions to maintain body temperature both inside and outside during cold weather by heating the home (taking care to avoid carbon monoxide intoxication), especially at night, and by wearing properly insulated clothes while performing outdoor activities. The outer layer of clothing should be tightly woven and wind resistant. Inside layers of wool, silk, or polypropylene are preferred over cotton. Persistent shivering always is a signal to return indoors.

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Public Health Dispatch

Outbreaks of Community-Associated Methicillin-Resistant *Staphylococcus aureus* Skin Infections — Los Angeles County, California, 2002–2003

During 2002, the Los Angeles County Department of Health Services (LACDHS) investigated three community outbreaks of skin infections associated with methicillin-resistant *Staphylococcus aureus* (MRSA). MRSA commonly has occurred in health-care settings; however, recent investigations of community-associated MRSA (CA-MRSA) have identified infection in various settings, including correctional facilities, athletic teams, and others (CDC, unpublished data, 2002). This report describes investigations of CA-MRSA in Los Angeles County.

In September 2002, LACDHS investigated cases of MRSA infection in two athletes on the same team who were hospitalized with MRSA within the same week. No additional cases of MRSA have been identified. The source of MRSA infection for these patients has not been determined.

On November 22, 2002, physicians from two large infectious disease clinical practices notified LACDHS of MRSA skin infections among men who have sex with men (MSM). LACDHS has increased surveillance in selected clinics serving MSM and has begun a study of risk factors for infection among this population.

Currently, LACDHS is investigating an outbreak in the Los Angeles County Jail, in which 928 inmates had MRSA wound infections diagnosed in 2002. Patients were reported as having spider bites but subsequently were found to be infected with MRSA. Review of medical charts of 39 of the 66 inmates hospitalized with these infections indicated that all initially had skin infections, but 10 later had invasive disease, including bacteremia, endocarditis, or osteomyelitis. The Los Angeles County Jail is the largest jail system in the United States; 165,000 persons are incarcerated in the jail each year. LACDHS issued recommendations for the diagnosis and treatment of skin infections in the jail and is working with the Los Angeles County Sheriff's Department to review policies and procedures on laundry, showers, environmental cleaning, skin care, and control of person-to-person transmission.

In each of these outbreaks, antimicrobial susceptibility patterns from MRSA isolates of these patients have been similar, including resistance to fluoroquinolones. Molecular analysis by pulsed-field gel electrophoresis (PFGE) of isolates performed at the Los Angeles County Public Health Laboratory has identified a predominant strain common to all of these outbreaks. The PFGE pattern of the predominant strain also is consistent with PFGE patterns that CDC has identified in community outbreaks from other parts of the United States (CDC, unpublished data, 2003). Selected MRSA isolates will be sent to CDC to characterize their virulence factors and toxins.

LACDHS is advising health-care providers to be aware that MRSA is a documented cause of community-associated skin and soft tissue infections. Local treatment and incision and drainage remain first-line therapies for soft tissue infections. Clinicians who suspect MRSA skin and soft tissue infections should consider microbiologic culture of wounds and appropriate antimicrobial therapy.

Skin infections might be prevented by keeping cuts and abrasions clean by washing with soap and water. Previous investigations of MRSA infection clusters in community settings have identified MRSA transmission through sharing common objects (e.g., athletic equipment, towels, benches, and personal items) contaminated with MRSA (CDC, unpublished data, 2002). To prevent MRSA infections from spreading in health-care settings, health-care providers should use standard precautions and appropriate hand hygiene between treating patients, clean surfaces of examination rooms with commercial disinfectant or diluted bleach (1 tablespoon bleach in 1 quart water), and carefully dispose of dressings and other materials that come into contact with pus, nasal discharge, blood, and urine (*1*).

The outbreaks described in this report reflect the importance of CA-MRSA infections. In collaboration with state health departments, CDC is conducting active, population-based surveillance for CA-MRSA in selected regions of the United States to help characterize the incidence and risk factors for MRSA in the community.

Reported by: *Participating physicians and microbiologists; Los Angeles County Jail; Los Angeles County Dept of Health Svcs, Los Angeles County, California. Div of Healthcare Quality Promotion, National Center for Infectious Diseases, CDC.*

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Notice to Readers

Smallpox Vaccine Adverse Events Monitoring and Response System for the First Stage of the Smallpox Vaccination Program

Smallpox vaccination of civilian volunteer health-care workers began on January 24, 2003. As of February 4, a total of 37 states and counties have received shipments of smallpox vaccine,

and 18 states and counties have begun smallpox vaccination; no serious adverse events have been reported. To monitor the occurrence of adverse events associated with vaccination, both those expected on the basis of previous experience and possible new unexpected adverse events, CDC and state health departments have established the Smallpox Vaccine Adverse Events Monitoring and Response System. The system also will be used to monitor the effectiveness of contraindication screening, identify new contraindications, and coordinate the distribution of vaccinia immune globulin (VIG) and cidofovir to the civilian population. This notice describes the components of the system, delineates roles and responsibilities, and explains how data from the system will be compiled and communicated.

The first stage of the vaccination program targets 1) smallpox response teams designated by terrorism and public health authorities to conduct investigation and follow-up of initial smallpox cases and 2) health-care teams whose members are trained to provide medical care for initial smallpox patients (*1*). During this stage, the Institute of Medicine (IOM) has recommended active surveillance for adverse events following smallpox vaccination (*2*). To implement this recommendation among all vaccinees and their contacts, the system will track adverse events that require hospitalization or outpatient care, contraindications to vaccination among vaccinees or household contacts not identified at the time of vaccination, and vaccinia transmission to contacts of vaccinees. CDC also will collect data from persons experiencing more common, nonserious adverse events in a telephone survey of approximately 10,000 vaccinees from at least eight states and cities administered at days 10 and 21 following vaccination.

Successful monitoring of and response to adverse events following smallpox vaccination depends on the efforts of vaccination clinic staff, vaccination-site–care monitors at hospitals and other locations, health-care providers, state health departments, and CDC. At smallpox vaccination clinics, a unique identifying number will be assigned to each vaccinee, and each vaccinee's vaccination information will be entered into an electronic tracking system (either the Pre-event Vaccination System (PVS) maintained by CDC or the state equivalent). In the days following vaccination, monitors at hospitals and other locations should assess vaccination-site care, symptoms reported by the vaccinees, and vaccine take (i.e., response to vaccination). For hospital staff, monitors also should determine fitness for duty. CDC's web-based Hospital Smallpox Vaccine Monitoring System can be used to facilitate monitoring and to enter tracking data. Vaccination-site–care monitors and health-care providers should report adverse events associated with vaccination as they occur (Table). When vaccination follow-up is completed (usually 21–28 days after vaccination), vaccination-site–care monitors should ensure that information about adverse events that require hospitalization or outpatient care, contraindications identified after vaccination, and contact transmission are documented for all vaccinees. CDC will provide a data entry mechanism linked to PVS for documenting this information.

TABLE. Adverse events after smallpox vaccination that are recommended to be reported to the Vaccine Adverse Event Reporting System and to state health departments*

Eczema vaccinatum
Erythema multiforme major or Stevens-Johnson syndrome
Fetal vaccinia
Generalized vaccinia
Inadvertent inoculation
Ocular vaccinia
Post-vaccinal encephalitis or encephalomyelitis
Progressive vaccinia
Pyogenic infection of vaccination site
Vaccinia transmission to contacts
Vaccination of persons with a contraindication to vaccination
Other serious adverse events (i.e., those resulting in hospitalization, permanent disability, life-threatening illness, or death)

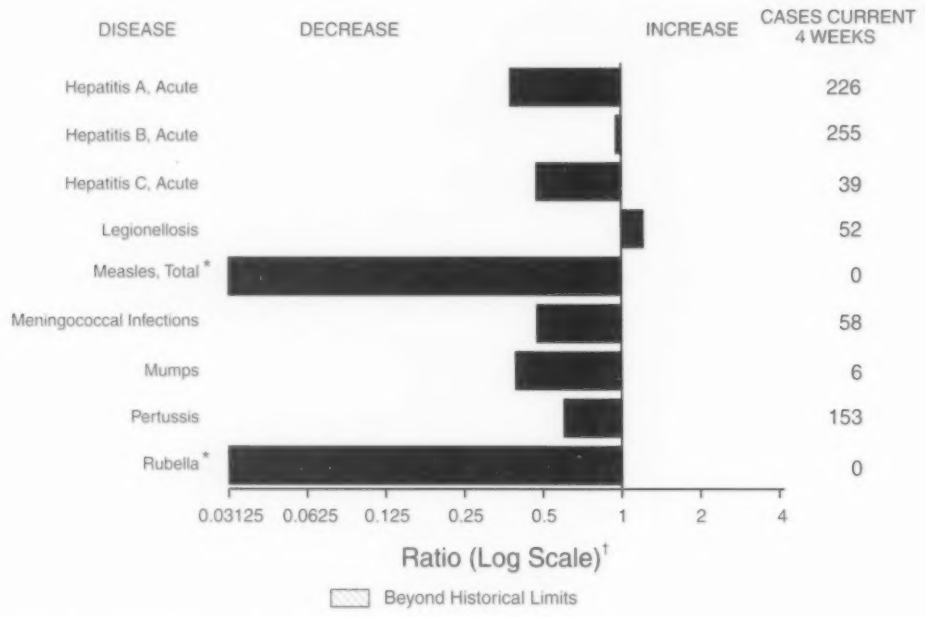
* Any adverse event that is of concern to the clinician or patient should be reported.

Health-care providers who need assistance with evaluating a smallpox vaccinee with a potential adverse event should contact their state health department or CDC's Clinician Information Line, telephone 877-554-4625. Staffed by nurses 24 hours a day, 7 days a week, this information line is a source for general smallpox clinical adverse event information and for assistance with adverse event reporting. As needed for clinical consultation and release of VIG and cidofovir, callers to this line will be connected to CDC's Smallpox Vaccine Adverse Events Clinical Consultation Team, whose members are experts in infectious diseases, ophthalmology, and neurology, and have back-up from smallpox/vaccinia disease experts. For general information about diagnosis and management of smallpox vaccination–associated adverse events, health-care providers should consult CDC's guidance for clinicians (*3*). Clinical evaluation tools to assist health-care providers in the diagnosis and management of smallpox vaccine adverse events also are available at http://www.bt.cdc.gov/agent/smallpox/vaccination/clineval.

Adverse events following smallpox vaccination should be reported to state health departments and the Vaccine Adverse Event Reporting System (VAERS), the national surveillance system for adverse events following the administration of U.S.-licensed vaccines (*4,5*). Any adverse event that is of concern to the clinician or patient should be reported. In addition, certain events are recommended to be reported (Table). Those adverse events that require VIG or cidofovir should be reported immediately (*3*). Other serious adverse events (i.e.,

(Continued on pg 99)

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending February 1, 2003, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 5 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending February 1, 2003 (5th Week)*

	Cum. 2003	Cum. 2002		Cum. 2003	Cum. 2002
Anthrax	-	-	Hansen disease (leprosy)†	4	3
Botulism:	-	-	Hantavirus pulmonary syndrome†	3	-
foodborne	-	3	Hemolytic uremic syndrome, postdiarrheal†	6	8
infant	5	7	HIV infection, pediatric†§	-	21
other (wound & unspecified)	2	3	Measles, total¶	-	-
Brucellosis†	2	7	Mumps	13	15
Chancroid	2	3	Plague	-	-
Cholera	-	-	Poliomyelitis, paralytic	-	-
Cyclosporiasis†	-	10	Psittacosis†	3	8
Diphtheria	-	-	Q fever†	2	2
Ehrlichiosis:	-	-	Rabies, human	-	-
human granulocytic (HGE)†	7	7	Rubella	-	-
human monocytic (HME)†	6	1	Rubella, congenital	-	1
other and unspecified	-	-	Streptococcal toxic-shock syndrome†	7	9
Encephalitis/Meningitis:	-	-	Tetanus	1	-
California serogroup viral†	-	-	Toxic-shock syndrome	3	11
eastern equine†	-	-	Trichinosis	-	2
Powassan†	-	-	Tularemia†	2	2
St. Louis†	-	-	Yellow fever	-	-
western equine†	-	-			

-: No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update December 22, 2002.
¶ No cases of indigenous or imported measles were reported.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 1, 2003, and February 2, 2002 (5th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2003§	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	-	3,372	51,862	67,296	329	134	87	181	-	-
NEW ENGLAND	-	111	1,824	2,387	-	-	5	6	-	-
Maine	-	1	138	130	N	N	-	-	-	-
N.H.	-	2	147	157	-	-	-	1	-	-
Vt.	-	3	94	71	-	-	1	-	-	-
Mass.	-	76	428	949	-	-	2	2	-	-
R.I.	-	5	269	263	-	-	1	3	-	-
Conn.	-	24	748	817	-	-	1	-	-	-
MID. ATLANTIC	-	835	2,022	7,162	-	-	24	19	-	-
Upstate N.Y.	-	46	940	520	-	-	3	1	-	-
N.Y. City	-	587	405	2,879	-	-	20	13	-	-
N.J.	-	145	677	1,259	-	-	-	1	-	-
Pa.	-	57	-	2,504	N	N	1	4	-	-
E.N. CENTRAL	-	370	12,072	12,460	1	2	11	57	-	-
Ohio	-	103	5,405	3,729	-	-	7	10	-	-
Ind.	-	52	1,273	1,405	N	N	-	3	-	-
Ill.	-	176	1,581	3,744	-	-	-	13	-	-
Mich.	-	31	2,636	2,012	1	2	4	9	-	-
Wis.	-	8	1,177	1,570	-	-	-	22	-	-
W.N. CENTRAL	-	48	2,271	3,702	-	-	9	6	-	-
Minn.	-	9	161	1,038	-	-	4	2	-	-
Iowa	-	15	174	180	N	N	2	1	-	-
Mo.	-	22	847	1,275	-	-	1	2	-	-
N. Dak.	-	-	19	82	N	N	-	-	-	-
S. Dak.	-	-	220	198	-	-	2	-	-	-
Nebr.	-	-	114	237	-	-	-	1	-	-
Kans.	-	2	736	692	N	N	-	-	-	-
S. ATLANTIC	-	1,093	11,264	11,568	-	-	19	37	-	-
Del.	-	21	293	229	N	N	1	-	-	-
Md.	-	140	1,537	1,330	-	-	3	-	-	-
D.C.	-	19	345	315	-	-	-	1	-	-
Va.	-	107	1,339	1,296	-	-	-	-	-	-
W. Va.	-	6	224	240	N	N	-	-	-	-
N.C.	-	45	2,120	1,388	-	-	2	3	-	-
S.C.	-	102	138	1,272	-	-	1	-	-	-
Ga.	-	375	2,136	1,874	-	-	9	27	-	-
Fla.	-	278	3,132	3,624	N	N	3	6	-	-
E.S. CENTRAL	-	136	4,573	4,757	-	-	6	7	-	-
Ky.	-	16	581	782	-	-	-	1	-	-
Tenn.	-	66	1,260	1,587	-	-	2	-	-	-
Ala.	-	20	1,365	1,433	-	-	4	5	-	-
Miss.	-	34	1,367	955	N	N	-	1	-	-
W.S. CENTRAL	-	379	8,555	9,831	-	-	1	5	-	-
Ark.	-	15	532	648	-	-	1	2	-	-
La.	-	65	1,255	1,667	N	N	-	-	-	-
Okla.	-	7	505	829	N	N	-	-	-	-
Tex.	-	292	6,263	6,687	-	-	-	3	-	-
MOUNTAIN	-	106	2,353	4,262	290	67	6	6	-	-
Mont.	-	3	129	228	-	-	-	-	-	-
Idaho	-	1	152	150	-	-	3	2	-	-
Wyo.	-	1	106	58	-	-	-	-	-	-
Colo.	-	20	736	1,255	N	N	2	1	-	-
N. Mex.	-	6	43	705	-	1	-	-	-	-
Ariz.	-	39	681	1,301	288	60	1	-	-	-
Utah	-	7	186	29	1	2	-	2	-	-
Nev.	-	29	320	536	1	4	-	1	-	-
PACIFIC	-	294	6,928	11,167	38	65	6	38	-	-
Wash.	-	1	1,312	1,137	N	N	-	U	-	-
Oreg.	-	75	395	510	-	-	2	6	-	-
Calif.	-	215	4,610	8,840	38	65	4	32	-	-
Alaska	-	-	287	278	-	-	-	-	-	-
Hawaii	-	3	324	402	-	-	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	68	78	179	N	N	-	-	-	-
V.I.	-	33	-	23	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update December 22, 2002.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 1, 2003, and February 2, 2002 (5th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	63	115	3	5	3	2	1,286	1,202	23,573	31,505
NEW ENGLAND	6	6	-	1	-	-	49	133	506	784
Maine	-	-	-	-	-	-	8	13	5	7
N.H.	-	1	-	-	-	-	4	8	11	9
Vt.	-	-	-	-	-	-	6	14	11	14
Mass.	3	1	-	1	-	-	30	74	110	375
R.I.	-	1	-	-	-	-	1	8	105	82
Conn.	3	3	-	-	-	-	-	16	264	297
MID. ATLANTIC	3	8	-	-	-	-	472	249	1,076	3,387
Upstate N.Y.	3	5	-	-	-	-	34	36	482	328
N.Y. City	-	-	-	-	-	-	425	104	129	1,214
N.J.	-	3	-	-	-	-	6	45	465	792
Pa.	N	N	-	-	-	-	7	64	-	1,053
E.N. CENTRAL	12	38	-	-	1	1	167	290	6,485	6,369
Ohio	4	7	-	-	1	1	99	74	3,414	2,066
Ind.	-	2	-	-	-	-	-	-	520	660
Ill.	-	16	-	-	-	-	2	99	796	2,042
Mich.	6	4	-	-	-	-	61	65	1,312	1,043
Wis.	2	9	-	-	-	-	5	52	443	558
W.N. CENTRAL	12	21	-	2	1	-	81	92	909	1,712
Minn.	6	6	-	2	-	-	6	13	73	327
Iowa	1	6	-	-	-	-	27	22	31	63
Mo.	2	2	N	N	N	N	14	26	507	835
N. Dak.	-	-	-	-	1	-	2	-	1	1
S. Dak.	-	-	-	-	-	-	3	7	7	24
Nebr.	3	4	-	-	-	-	12	11	5	111
Kans.	-	3	-	-	-	-	17	13	285	351
S. ATLANTIC	9	15	1	1	-	-	223	223	6,177	7,623
Del.	-	1	-	-	-	-	5	6	147	174
Md.	-	-	-	-	-	-	10	15	802	775
D.C.	-	-	-	-	-	-	-	6	286	284
Va.	1	1	-	-	-	-	11	5	645	901
W. Va.	-	-	-	-	-	-	-	-	80	86
N.C.	3	3	-	-	-	-	-	-	1,303	1,385
S.C.	-	-	-	-	-	-	4	-	120	795
Ga.	-	10	-	-	-	-	125	34	1,221	1,184
Fla.	5	-	1	1	-	-	68	157	1,573	2,039
E.S. CENTRAL	5	-	-	-	-	-	26	19	2,569	2,922
Ky.	-	-	-	-	-	-	-	-	285	332
Tenn.	3	-	-	-	-	-	11	2	678	984
Ala.	2	-	-	-	-	-	15	17	890	979
Miss.	-	-	-	-	-	-	-	-	716	627
W.S. CENTRAL	1	3	-	-	-	1	16	7	3,870	4,910
Ark.	1	-	-	-	-	-	13	7	380	511
La.	-	-	-	-	-	-	-	-	861	1,148
Okla.	-	-	-	-	-	-	3	-	223	373
Tex.	-	3	-	-	-	1	-	-	2,406	2,878
MOUNTAIN	5	5	2	1	1	-	112	97	591	1,118
Mont.	-	-	-	-	-	-	2	3	10	18
Idaho	1	1	1	-	-	-	17	2	7	9
Wyo.	-	-	-	1	-	-	2	-	6	4
Colo.	1	1	-	-	1	-	36	43	223	395
N. Mex.	-	1	1	-	-	-	1	13	23	141
Ariz.	1	-	-	-	-	-	27	6	196	378
Utah	2	-	-	-	-	-	15	14	17	1
Nev.	-	2	-	-	-	-	12	16	109	172
PACIFIC	10	19	-	-	-	-	140	92	1,390	2,680
Wash.	3	3	-	-	-	-	3	16	247	266
Oreg.	1	5	-	-	-	-	25	58	71	86
Calif.	4	11	-	-	-	-	96	-	949	2,213
Alaska	-	-	-	-	-	-	8	8	45	61
Hawaii	2	-	-	-	-	-	8	10	78	54
Guam	N	N	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	-	8	53
V.I.	-	-	-	-	-	-	-	-	-	7
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 1, 2003, and February 2, 2002 (5th Week)*

Reporting area	*Haemophilus influenzae*, invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype B		Non-serotype B		Unknown serotype		A	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	92	149	2	-	13	18	-	-	345	868
NEW ENGLAND	10	11	-	-	-	1	-	-	9	44
Maine	-	-	-	-	-	-	-	-	-	1
N.H.	3	-	-	-	-	-	-	-	-	1
Vt.	4	-	-	-	-	-	-	-	1	-
Mass.	1	8	-	-	-	1	-	-	6	24
R.I.	-	-	-	-	-	-	-	-	-	2
Conn.	2	3	-	-	-	-	-	-	2	16
MID. ATLANTIC	9	32	-	-	3	1	-	-	54	88
Upstate N.Y.	4	13	-	-	1	1	-	-	3	6
N.Y. City	4	10	-	-	2	-	-	-	51	25
N.J.	1	7	-	-	-	-	-	-	-	26
Pa.	-	2	-	-	-	-	-	-	-	31
E.N. CENTRAL	7	32	1	-	1	4	-	-	37	107
Ohio	4	17	-	-	1	1	-	-	16	24
Ind.	1	3	-	-	-	1	-	-	1	1
Ill.	-	11	-	-	-	2	-	-	1	50
Mich.	2	1	1	-	-	-	-	-	18	22
Wis.	-	-	-	-	-	-	-	-	1	10
W.N. CENTRAL	3	2	-	-	1	-	-	-	13	36
Minn.	1	-	-	-	-	-	-	-	-	-
Iowa	-	1	-	-	-	-	-	-	6	8
Mo.	1	1	-	-	-	-	-	-	1	8
N. Dak.	-	-	-	-	-	-	-	-	1	-
S. Dak.	-	-	-	-	-	-	-	-	-	1
Nebr.	-	-	-	-	-	-	-	-	1	1
Kans.	1	-	-	-	1	-	-	-	4	18
S. ATLANTIC	25	40	-	-	2	6	-	-	133	225
Del.	-	-	-	-	-	-	-	-	-	2
Md.	7	12	-	-	1	-	-	-	20	46
D.C.	-	-	-	-	-	-	-	-	-	8
Va.	1	3	-	-	-	1	-	-	1	2
W. Va.	-	-	-	-	-	-	-	-	-	-
N.C.	1	3	-	-	-	-	-	-	4	31
S.C.	1	-	-	-	-	-	-	-	6	3
Ga.	4	13	-	-	-	2	-	-	57	33
Fla.	11	9	-	-	1	3	-	-	45	100
E.S. CENTRAL	11	1	-	-	2	1	-	-	10	40
Ky.	1	-	-	-	-	-	-	-	1	6
Tenn.	4	-	-	-	1	-	-	-	6	13
Ala.	6	1	-	-	1	1	-	-	3	5
Miss.	-	-	-	-	-	-	-	-	-	16
W.S. CENTRAL	7	2	-	-	1	1	-	-	3	93
Ark.	1	-	-	-	-	-	-	-	-	4
La.	2	-	-	-	-	-	-	-	2	2
Okla.	4	2	-	-	1	1	-	-	1	3
Tex.	-	-	-	-	-	-	-	-	-	84
MOUNTAIN	15	14	1	-	2	2	-	-	25	41
Mont.	-	-	-	-	-	-	-	-	-	2
Idaho	-	-	-	-	-	-	-	-	-	5
Wyo.	-	-	-	-	-	-	-	-	-	2
Colo.	2	3	-	-	-	-	-	-	4	8
N. Mex.	2	2	-	-	-	1	-	-	-	3
Ariz.	7	6	1	-	1	1	-	-	15	9
Utah	3	3	-	-	1	-	-	-	3	3
Nev.	1	-	-	-	-	-	-	-	3	9
PACIFIC	5	15	-	-	1	2	-	-	61	194
Wash.	-	-	-	-	-	-	-	-	2	4
Oreg.	4	9	-	-	1	1	-	-	7	18
Calif.	-	1	-	-	-	1	-	-	51	172
Alaska	-	-	-	-	-	-	-	-	1	-
Hawaii	1	5	-	-	-	-	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	-	-	6
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 1, 2003, and February 2, 2002 (5th Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C							
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	434	396	81	334	72	65	28	33	252	392
NEW ENGLAND	12	18	-	2	2	3	3	2	2	39
Maine	-	-	-	-	-	-	-	1	-	-
N.H.	-	2	-	-	-	-	1	-	-	6
Vt.	1	1	-	1	1	-	-	-	2	-
Mass.	11	12	-	1	-	2	2	-	-	33
R.I.	-	-	-	-	-	-	-	-	-	-
Conn.	-	3	-	-	1	1	-	1	-	-
MID. ATLANTIC	80	108	30	189	9	13	7	5	203	269
Upstate N.Y.	-	3	1	1	3	2	2	3	143	146
N.Y. City	54	59	-	-	6	-	4	1	53	-
N.J.	23	30	29	186	-	3	-	-	5	63
Pa.	3	16	-	2	-	8	1	1	2	60
E.N. CENTRAL	37	37	11	5	22	27	3	8	2	10
Ohio	18	6	1	-	13	18	3	3	2	2
Ind.	-	-	-	-	-	-	-	-	-	1
Ill.	-	3	1	-	-	-	-	1	-	-
Mich.	19	24	9	5	9	7	-	1	-	-
Wis.	-	4	-	-	-	2	-	3	U	7
W.N. CENTRAL	12	20	10	51	1	2	2	1	1	6
Minn.	-	1	-	-	-	-	1	-	-	1
Iowa	1	3	-	-	-	-	-	-	-	3
Mo.	7	9	9	49	-	1	-	1	-	2
N. Dak.	1	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-
Nebr.	2	4	1	2	-	1	1	-	-	-
Kans.	1	3	-	-	1	-	-	-	1	-
S. ATLANTIC	192	89	15	9	28	5	6	3	32	51
Del.	1	1	-	3	-	1	-	-	-	6
Md.	5	14	1	2	7	3	1	1	21	39
D.C.	-	1	-	-	-	-	-	-	-	2
Va.	1	2	-	-	2	-	-	-	-	-
W. Va.	-	1	-	-	N	N	-	-	-	-
N.C.	13	12	1	2	2	-	1	-	5	-
S.C.	-	2	-	-	-	-	1	1	-	-
Ga.	133	12	1	-	2	-	1	-	1	-
Fla.	39	44	12	2	15	1	2	1	5	4
E.S. CENTRAL	15	32	6	16	1	-	2	-	1	-
Ky.	-	4	1	1	-	-	-	-	-	-
Tenn.	3	8	-	-	1	-	-	-	1	-
Ala.	6	7	-	1	-	-	2	-	-	-
Miss.	6	13	5	14	-	-	-	-	-	-
W.S. CENTRAL	2	10	2	51	2	2	-	4	-	7
Ark.	-	9	-	4	-	-	-	-	-	-
La.	2	1	2	-	-	-	-	-	-	1
Okla.	-	-	-	-	2	-	-	-	-	-
Tex.	-	-	-	47	-	2	-	4	-	6
MOUNTAIN	49	22	3	4	4	3	5	2	1	1
Mont.	1	-	-	-	-	-	1	-	-	-
Idaho	-	-	-	-	1	-	-	-	1	-
Wyo.	1	2	-	2	-	-	-	-	-	-
Colo.	11	8	3	1	-	1	2	1	-	-
N. Mex.	-	3	-	-	-	1	-	-	-	1
Ariz.	31	1	-	-	2	-	2	1	-	-
Utah	4	3	-	-	1	1	-	-	-	-
Nev.	1	5	-	1	-	-	-	-	-	-
PACIFIC	35	60	4	7	3	10	-	8	10	9
Wash.	1	-	-	-	-	-	-	-	-	-
Oreg.	10	16	1	2	N	N	-	1	3	1
Calif.	24	43	3	5	3	10	-	7	7	8
Alaska	-	1	-	-	-	-	-	-	-	-
Hawaii	-	-	-	-	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	3	-	-	-	-	-	1	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 1, 2003, and February 2, 2002 (5th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	68	82	95	163	264	408	259	451	19	25
NEW ENGLAND	1	8	4	10	62	100	38	40	-	-
Maine	1	-	-	1	-	3	-	2	-	-
N.H.	-	3	-	1	-	-	2	-	-	-
Vt.	-	-	-	2	14	14	2	11	-	-
Mass.	-	3	3	6	48	78	15	14	-	-
R.I.	-	-	-	-	-	-	-	2	-	-
Conn.	-	2	1	-	-	5	19	11	-	-
MID. ATLANTIC	26	18	7	23	20	15	25	64	1	3
Upstate N.Y.	2	1	2	6	20	12	18	43	-	-
N.Y. City	24	7	4	4	-	3	5	2	1	-
N.J.	-	9	-	3	-	-	-	10	-	-
Pa.	-	1	1	10	-	-	2	9	-	3
E.N. CENTRAL	4	10	15	28	36	56	1	1	1	1
Ohio	2	3	6	14	32	27	-	-	1	1
Ind.	-	-	4	4	-	-	-	1	-	-
Ill.	-	4	-	2	-	8	-	-	-	-
Mich.	2	3	4	4	3	9	1	-	-	-
Wis.	-	-	1	4	1	12	-	-	-	-
W.N. CENTRAL	4	4	5	7	10	31	36	31	1	-
Minn.	2	-	1	-	-	-	3	1	-	-
Iowa	2	1	2	-	-	6	3	4	1	-
Mo.	-	2	1	4	6	16	-	-	-	-
N. Dak.	-	-	-	-	-	-	5	-	-	-
S. Dak.	-	-	-	1	-	1	-	14	-	-
Nebr.	-	-	-	1	-	2	-	-	-	-
Kans.	-	1	1	1	4	6	25	12	-	-
S. ATLANTIC	22	13	23	20	47	18	140	104	14	20
Del.	-	-	4	-	-	1	-	-	-	-
Md.	10	8	2	1	10	4	2	36	4	5
D.C.	-	2	-	-	-	-	-	-	-	-
Va.	-	-	-	-	1	3	36	22	-	-
W. Va.	1	-	-	-	-	-	4	11	-	-
N.C.	2	2	3	3	17	7	46	32	10	15
S.C.	-	1	-	-	-	2	11	3	-	-
Ga.	3	-	1	5	13	-	35	-	-	-
Fla.	6	-	13	11	6	1	6	-	-	-
E.S. CENTRAL	2	3	7	8	10	18	4	108	1	1
Ky.	-	-	-	-	2	6	3	-	-	-
Tenn.	-	1	2	1	2	5	-	108	1	1
Ala.	2	1	2	6	6	1	1	-	-	-
Miss.	-	1	3	1	-	6	-	-	-	-
W.S. CENTRAL	1	1	6	26	-	65	5	76	-	-
Ark.	-	-	1	4	-	57	-	-	-	-
La.	1	1	3	2	-	-	-	-	-	-
Okla.	-	-	2	1	-	1	5	10	-	-
Tex.	-	-	-	19	-	7	-	66	-	-
MOUNTAIN	1	2	4	10	61	55	7	12	-	-
Mont.	-	-	-	-	-	2	1	-	-	-
Idaho	-	-	-	-	2	5	-	-	-	-
Wyo.	-	-	-	-	-	2	-	1	-	-
Colo.	-	1	-	4	33	32	-	-	-	-
N. Mex.	-	-	1	-	3	10	-	-	-	-
Ariz.	1	-	3	2	14	-	6	11	-	-
Utah	-	-	-	-	6	3	-	-	-	-
Nev.	-	1	-	4	3	1	-	-	-	-
PACIFIC	7	23	24	31	18	50	3	15	1	-
Wash.	2	-	2	6	2	3	-	-	-	-
Oreg.	4	-	7	6	16	11	-	-	-	-
Calif.	1	21	14	18	-	33	3	6	1	-
Alaska	-	-	-	-	-	1	-	9	-	-
Hawaii	-	2	1	1	-	2	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	1	-	-	-	8	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 1, 2003, and February 2, 2002 (5th Week)*

Reporting area	Salmonellosis		Shigellosis		*Streptococcal* disease, invasive, group A		*Streptococcus pneumoniae*, invasive			
							Drug resistant, all ages		Age <5 years	
	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002	Cum. 2003	Cum. 2002
UNITED STATES	1,671	2,359	1,249	1,254	274	363	206	150	31	11
NEW ENGLAND	74	104	19	21	7	18	2	-	-	1
Maine	2	12	-	-	-	3	-	-	-	-
N.H.	4	3	-	-	1	2	-	-	N	N
Vt.	1	5	-	-	2	1	2	-	-	1
Mass.	48	60	12	20	4	12	N	N	N	N
R.I.	4	4	2	-	-	-	-	-	-	-
Conn.	15	20	5	1	-	-	-	-	-	-
MID. ATLANTIC	154	266	75	62	39	65	5	5	5	1
Upstate N.Y.	24	19	12	5	23	18	5	5	5	1
N.Y. City	114	98	49	35	11	25	U	U	U	U
N.J.	6	80	5	6	1	19	N	N	N	N
Pa.	10	69	9	16	4	3	-	-	-	-
E.N. CENTRAL	208	402	62	174	66	91	41	8	23	8
Ohio	132	60	30	71	30	16	41	-	22	-
Ind.	13	16	5	4	1	3	-	7	1	2
Ill.	7	215	3	72	-	29	-	1	-	-
Mich.	46	65	22	19	34	25	-	-	N	N
Wis.	10	46	2	8	1	18	N	N	-	6
W.N. CENTRAL	92	136	54	157	15	19	26	28	1	-
Minn.	28	23	2	19	-	-	-	-	1	-
Iowa	21	18	1	10	-	-	N	N	N	N
Mo.	22	58	18	19	3	9	-	1	-	-
N. Dak.	2	-	-	-	-	-	-	-	-	-
S. Dak.	5	9	4	72	3	-	-	-	-	-
Nebr.	6	9	22	23	6	6	2	9	N	N
Kans.	8	19	7	14	3	4	24	18	N	N
S. ATLANTIC	676	664	786	427	58	77	111	86	-	1
Del.	2	3	46	2	1	-	-	2	N	N
Md.	58	56	92	36	18	-	-	-	-	-
D.C.	-	6	-	3	-	2	-	3	-	1
Va.	26	46	19	92	-	5	N	N	N	N
W. Va.	-	2	-	1	-	-	3	1	-	-
N.C.	137	86	92	24	8	14	N	N	U	U
S.C.	38	15	11	5	1	2	9	14	N	N
Ga.	190	131	259	158	8	32	30	42	N	N
Fla.	225	319	267	106	22	11	69	24	N	N
E.S. CENTRAL	143	132	67	85	5	7	8	15	-	-
Ky.	19	14	3	21	1	2	-	-	N	N
Tenn.	43	26	18	5	4	5	8	15	N	N
Ala.	62	56	39	27	-	-	-	-	N	N
Miss.	19	36	7	32	-	-	-	-	-	-
W.S. CENTRAL	29	144	48	97	6	30	10	3	2	-
Ark.	16	22	1	14	1	-	-	2	-	-
La.	6	7	7	8	-	-	10	1	-	-
Okla.	7	17	40	23	5	4	N	N	2	-
Tex.	-	98	-	52	-	26	N	N	-	-
MOUNTAIN	98	98	57	28	60	24	3	5	-	-
Mont.	2	3	-	-	-	-	-	-	-	-
Idaho	9	6	1	1	4	-	N	N	N	N
Wyo.	1	4	1	-	-	1	1	2	-	-
Colo.	33	41	14	9	16	9	-	-	-	-
N. Mex.	9	10	12	3	7	12	2	3	-	-
Ariz.	25	4	25	4	31	-	-	-	N	N
Utah	11	11	2	5	2	2	-	-	-	-
Nev.	8	19	2	6	-	-	-	-	-	-
PACIFIC	197	413	81	203	18	32	-	-	-	-
Wash.	15	5	-	-	-	-	-	-	N	N
Oreg.	16	29	6	14	N	N	N	N	N	N
Calif.	142	357	69	183	8	23	N	N	N	N
Alaska	10	9	2	1	-	-	-	-	N	N
Hawaii	14	13	4	5	10	9	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	5	-	1	N	N	-	-	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 1, 2003, and February 2, 2002 (5th Week)*

Reporting area	Syphilis: Primary & secondary Cum. 2003	Syphilis: Primary & secondary Cum. 2002	Syphilis: Congenital Cum. 2003	Syphilis: Congenital Cum. 2002	Tuberculosis Cum. 2003	Tuberculosis Cum. 2002	Typhoid fever Cum. 2003	Typhoid fever Cum. 2002	Varicella (Chickenpox) Cum. 2003
UNITED STATES	479	483	13	30	231	612	16	20	1,263
NEW ENGLAND	8	4	-	-	4	19	1	4	345
Maine	-	-	-	-	-	-	-	-	199
N.H.	-	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	-	-	-	112
Mass.	5	2	-	-	3	1	-	3	34
R.I.	3	-	-	-	-	7	-	-	-
Conn.	-	2	-	-	1	11	1	1	-
MID. ATLANTIC	43	41	3	7	88	80	6	3	-
Upstate N.Y.	1	1	1	1	-	2	-	-	-
N.Y. City	26	18	1	3	86	28	6	2	-
N.J.	16	13	1	3	-	29	-	1	-
Pa.	-	9	-	-	2	21	-	-	-
E.N. CENTRAL	63	76	5	4	30	61	2	2	642
Ohio	18	10	1	-	8	9	-	1	161
Ind.	1	8	-	-	11	9	1	-	-
Ill.	10	21	3	3	9	41	-	-	-
Mich.	32	34	1	1	-	-	1	-	465
Wis.	2	3	-	-	2	2	-	1	16
W.N. CENTRAL	8	10	-	-	14	36	-	1	1
Minn.	-	5	-	-	5	10	-	1	-
Iowa	-	-	-	-	-	-	-	-	-
Mo.	1	2	-	-	-	18	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	1
S. Dak.	-	-	-	-	4	-	-	-	-
Nebr.	-	2	-	-	-	-	-	-	-
Kans.	7	1	-	-	5	8	-	-	-
S. ATLANTIC	153	117	3	5	8	86	2	6	268
Del.	1	2	-	-	-	-	-	-	1
Md.	24	10	-	-	-	-	2	1	-
D.C.	5	1	-	-	-	-	-	-	-
Va.	6	3	-	-	3	1	-	-	50
W. Va.	-	-	-	-	1	3	-	-	212
N.C.	20	39	-	2	2	6	-	-	-
S.C.	8	9	1	1	2	2	-	-	5
Ga.	22	13	-	1	-	7	-	1	-
Fla.	67	40	2	1	-	67	-	4	-
E.S. CENTRAL	29	61	2	2	12	37	-	-	-
Ky.	5	1	-	-	-	6	-	-	-
Tenn.	12	25	2	1	-	19	-	-	-
Ala.	11	22	-	-	12	10	-	-	-
Miss.	1	13	-	1	-	2	-	-	-
W.S. CENTRAL	71	69	-	8	5	148	-	3	-
Ark.	7	1	-	-	4	2	-	-	-
La.	9	17	-	-	-	-	-	-	-
Okla.	2	8	-	-	1	1	-	-	-
Tex.	53	43	-	8	-	145	-	3	-
MOUNTAIN	14	30	-	1	8	20	2	-	7
Mont.	-	-	-	-	-	-	-	-	-
Idaho	-	1	-	-	-	-	-	-	-
Wyo.	-	-	-	-	1	1	-	-	2
Colo.	-	1	-	-	2	4	2	-	-
N. Mex.	3	3	-	-	-	5	-	-	-
Ariz.	11	25	-	1	5	6	-	-	-
Utah	-	-	-	-	-	1	-	-	5
Nev.	-	-	-	-	-	3	-	-	-
PACIFIC	90	75	-	3	62	125	3	1	-
Wash.	7	1	-	-	18	12	-	-	-
Oreg.	5	4	-	-	4	3	1	-	-
Calif.	76	69	-	3	27	88	2	1	-
Alaska	-	-	-	-	3	9	-	-	-
Hawaii	2	1	-	-	10	13	-	-	-
Guam	-	-	-	-	-	-	-	-	-
P.R.	7	18	-	4	-	-	-	-	-
V.I.	-	1	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2002 and 2003 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending February 1, 2003 (5th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	516	363	99	28	14	12	51
Boston, Mass.	179	114	39	14	3	9	10
Bridgeport, Conn.	30	24	4	2	-	-	5
Cambridge, Mass.	24	21	2	1	-	-	2
Fall River, Mass.	25	22	3	-	-	-	5
Hartford, Conn.	49	13	19	4	10	3	2
Lowell, Mass.	20	16	4	-	-	-	2
Lynn, Mass.	7	3	4	-	-	-	1
New Bedford, Mass.	31	27	3	1	-	-	2
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	4	3	1	-	-	-	-
Springfield, Mass.	49	37	9	3	-	-	5
Waterbury, Conn.	33	28	3	2	-	-	3
Worcester, Mass.	65	55	8	1	1	-	14
MID. ATLANTIC	2,666	1,924	521	135	55	29	146
Albany, N.Y.	63	42	16	3	1	1	4
Allentown, Pa.	26	25	1	-	-	-	6
Buffalo, N.Y.	103	78	21	3	-	1	11
Camden, N.J.	28	20	5	1	2	-	3
Elizabeth, N.J.	26	22	3	1	-	-	-
Erie, Pa.	57	46	8	1	2	-	-
Jersey City, N.J.	49	35	10	3	1	-	-
New York City, N.Y.	1,439	1,018	305	72	24	20	66
Newark, N.J.	54	23	19	10	2	-	5
Paterson, N.J.	22	12	8	1	1	-	-
Philadelphia, Pa.	351	256	58	18	16	3	11
Pittsburgh, Pa.§	44	32	5	4	1	-	3
Reading, Pa.	28	22	4	2	-	-	2
Rochester, N.Y.	154	127	20	1	3	3	16
Schenectady, N.Y.	24	20	3	1	-	-	2
Scranton, Pa.	29	21	7	1	-	-	1
Syracuse, N.Y.	91	69	15	5	2	-	10
Trenton, N.J.	35	24	7	3	-	1	3
Utica, N.Y.	12	11	-	1	-	-	-
Yonkers, N.Y.	31	21	6	4	-	-	3
E.N. CENTRAL	2,203	1,462	480	140	57	64	146
Akron, Ohio	65	51	6	5	-	3	5
Canton, Ohio	42	29	11	2	-	-	7
Chicago, Ill.	392	239	107	22	16	8	25
Cincinnati, Ohio	60	40	11	6	1	2	10
Cleveland, Ohio	164	107	35	11	6	5	10
Columbus, Ohio	224	153	47	14	3	7	16
Dayton, Ohio	134	92	27	10	2	3	13
Detroit, Mich.	189	106	43	19	12	9	17
Evansville, Ind.	48	36	8	3	1	-	4
Fort Wayne, Ind.	78	57	12	4	1	4	9
Gary, Ind.	23	11	9	3	-	-	2
Grand Rapids, Mich.	58	41	13	2	1	1	4
Indianapolis, Ind.	202	122	51	16	8	5	1
Lansing, Mich.	42	29	8	3	-	2	3
Milwaukee, Wis.	128	86	30	6	3	3	3
Peoria, Ill.	47	37	9	-	-	1	1
Rockford, Ill.	54	42	10	1	-	1	1
South Bend, Ind.	70	51	16	2	1	-	7
Toledo, Ohio	117	83	17	8	1	8	6
Youngstown, Ohio	66	50	10	3	1	2	2
W.N. CENTRAL	621	446	107	34	15	19	61
Des Moines, Iowa	111	80	24	4	1	2	19
Duluth, Minn.	30	24	4	1	-	1	2
Kansas City, Kans.	37	24	8	3	2	-	2
Kansas City, Mo.	95	63	14	9	1	8	6
Lincoln, Nebr.	41	36	3	2	-	-	3
Minneapolis, Minn.	61	40	11	3	3	4	-
Omaha, Nebr.	99	72	21	2	2	2	15
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	53	38	6	5	3	1	6
Wichita, Kans.	94	69	16	5	3	1	8
S. ATLANTIC	1,352	817	332	133	29	41	96
Atlanta, Ga.	246	138	55	29	7	17	12
Baltimore, Md.	100	50	32	16	1	1	9
Charlotte, N.C.	137	87	34	12	2	2	7
Jacksonville, Fla.	170	101	44	20	4	1	11
Miami, Fla.	122	80	23	12	2	5	14
Norfolk, Va.	54	34	15	5	-	-	3
Richmond, Va.	91	46	28	10	5	2	7
Savannah, Ga.	64	42	14	2	1	5	11
St. Petersburg, Fla.	49	35	8	4	1	1	4
Tampa, Fla.	217	145	45	15	6	6	15
Washington, D.C.	78	40	30	7	-	1	-
Wilmington, Del.	24	19	4	1	-	-	3
E.S. CENTRAL	1,099	731	239	78	26	23	101
Birmingham, Ala.	202	129	44	18	7	4	11
Chattanooga, Tenn.	97	69	20	6	1	1	8
Knoxville, Tenn.	91	62	22	5	2	-	5
Lexington, Ky.	93	66	17	6	4	-	7
Memphis, Tenn.	242	156	63	14	3	6	32
Mobile, Ala.	108	69	22	8	5	4	7
Montgomery, Ala.	62	43	17	2	-	-	4
Nashville, Tenn.	204	137	34	19	4	8	27
W.S. CENTRAL	1,795	1,116	375	149	91	64	124
Austin, Tex.	91	58	19	6	5	3	5
Baton Rouge, La.	64	49	6	4	3	2	2
Corpus Christi, Tex.	72	41	16	6	2	7	5
Dallas, Tex.	240	152	61	20	3	4	8
El Paso, Tex.	78	59	12	3	2	2	10
Ft. Worth, Tex.	155	100	37	12	4	2	12
Houston, Tex.	450	228	88	46	61	27	31
Little Rock, Ark.	79	52	16	4	4	3	1
New Orleans, La.	38	26	8	3	1	-	-
San Antonio, Tex.	284	189	63	24	1	7	28
Shreveport, La.	78	54	13	9	1	1	8
Tulsa, Okla.	166	108	36	12	4	6	14
MOUNTAIN	951	650	201	67	15	18	74
Albuquerque, N.M.	124	90	24	7	1	2	10
Boise, Idaho	41	31	5	3	1	1	4
Colo. Springs, Colo.	72	50	11	7	1	3	2
Denver, Colo.	104	58	25	12	5	4	8
Las Vegas, Nev.	274	176	70	20	1	7	20
Ogden, Utah	27	20	5	2	-	-	2
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	30	21	6	3	-	-	2
Salt Lake City, Utah	114	81	23	7	3	-	13
Tucson, Ariz.	165	123	32	6	3	1	13
PACIFIC	1,909	1,335	379	118	46	31	148
Berkeley, Calif.	12	8	3	1	-	-	-
Fresno, Calif.	91	67	16	4	3	1	2
Glendale, Calif.	23	17	2	3	1	-	1
Honolulu, Hawaii	90	63	16	8	3	-	7
Long Beach, Calif.	94	66	21	2	4	1	10
Los Angeles, Calif.	462	313	86	42	17	4	18
Pasadena, Calif.	23	18	2	1	2	-	2
Portland, Oreg.	216	155	47	10	2	2	13
Sacramento, Calif.	226	158	41	16	1	10	32
San Diego, Calif.	174	114	43	9	4	4	19
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	180	133	37	4	1	5	19
Santa Cruz, Calif.	33	23	6	2	2	-	8
Seattle, Wash.	118	73	29	11	3	2	10
Spokane, Wash.	48	32	12	3	1	-	3
Tacoma, Wash.	119	95	18	2	2	2	4
TOTAL	13,112¶	8,844	2,733	882	348	301	947

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

(Continued from pg 89)

those resulting in hospitalization, permanent disability, life-threatening illness, or death) should be reported within 48 hours after recognition. Reports may be submitted to VAERS at http://secure.vaers.org/vaersdataentry.intro, by toll-free fax at 877-721-0366, or by mail to P.O. Box 1100, Rockville, Maryland 20849-1100. Report forms and assistance with reporting are available from VAERS, telephone 800-822-7967.

CDC's secure web-based communications network for public health investigation and response, the *Epidemic Information Exchange* (*Epi-X*) (http://www.cdc.gov/mmwr/epix/epix.html), will be used for rapid and regular exchange of smallpox vaccine adverse events data among state and local health departments and CDC. These data will be tabulated regularly and reported on CDC's smallpox website and in *MMWR*. The reported rates of known serious adverse events will be compared with historically reported rates. If higher-than-expected rates of known adverse events or unexpected adverse events are detected from either active or passive surveillance analysis, further investigation will be conducted. A workgroup of the Advisory Committee on Immunization Practices will assess the data regularly. In addition, to ensure that the smallpox vaccination program is conducted safely and effectively, IOM will provide ongoing programmatic evaluation.

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The programs are designed for physicians, nurses, nurse practitioners, physician assistants, Department of Defense paraprofessionals, pharmacists, and their colleagues who either administer vaccinations or set policy for their offices, clinics, communicable disease or infection-control programs. The program also will target both private and public health-care providers, including pediatricians, family practice specialists, residents, and medical and nursing students. Each 3.5-hour broadcast will feature two question-and-answer sessions in which participants can interact with the course instructors through toll-free telephone lines. Continuing education credit will be offered for various professions based on 3 hours of instruction per session.

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